General Assembly

Raised Bill No. 1364

January Session, 2005

LCO No. **5248**

05248_____JUD

Referred to Committee on Judiciary

Introduced by:
(JUD)

AN ACT CONCERNING REFORMS RELATED TO MEDICAL MALPRACTICE INSURANCE.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective from passage*) (a) All civil actions brought to recover damages resulting from personal injury or wrongful death, whether in tort or in contract, in which it is alleged that such injury or death resulted from the negligence of a health care provider, shall be referred to mandatory mediation pursuant to this section, unless the parties have agreed to refer the civil action to an alternative dispute resolution program. For the purposes of this section, "health care provider" means a provider, as defined in subsection (b) of section 20-7b of the general statutes, or an institution, as defined in section 19a-490 of the general statutes.

(b) The purpose of such mandatory mediation shall be to (1) review the certificate of good faith filed pursuant to section 52-190a of the general statutes, as amended by this act, to determine whether there are grounds for a good faith belief that the defendant has been negligent in the care or treatment of the claimant, (2) attempt to achieve a prompt settlement or resolution of the case, and (3) expedite

the litigation of the case.

(c) Upon the filing of the answer in such action by the defendant, the clerk of the court for the judicial district in which the case is pending shall refer the case to a judge of the superior court for mediation. The mediation shall commence as soon as practicable, but not later than thirty days after the filing of the answer. The mediation shall not stay or delay the prosecution of the case, nor delay discovery in or the trial of the case.

(d) At the mediation, the court shall review the certificate of good faith filed pursuant to section 52-190a of the general statutes, as amended by this act, to determine whether there are grounds for a good faith belief that the defendant has been negligent in the care or treatment of the claimant. If the court determines that the certificate of good faith is inadequate to permit such a determination, it may order the party submitting the certificate to file, within thirty days, a supplemental certificate setting forth the grounds for the opinion that there has been negligence in the care or treatment of the claimant.

(e) If the court determines that the certificate of good faith or any supplemental certificate is inadequate to support a determination that there are grounds for a good faith belief that there has been negligence in the care or treatment of the claimant, it shall order the party asserting such a claim to post a cash or surety bond in the amount of five thousand dollars as a condition of continuing the prosecution of the case, which bond shall be used to pay the taxable costs of the other party, as permitted by the general statutes, in the event of the unsuccessful prosecution of the case.

(f) All parties to the case, together with a representative of each insurer that may be liable to pay all or part of any verdict or settlement in the case, shall attend the mediation in person, unless attendance by means of telephone is permitted upon written agreement of all parties or written order of the court.

(g) If the mediation does not settle or conclude the case, the court shall enter such orders as are necessary to narrow the issues, expedite discovery and assist the parties in preparing the case for trial.

Sec. 2. Section 52-190a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage and applicable to actions filed on or after said date*):

(a) No civil action or apportionment complaint shall be filed to recover damages resulting from personal injury or wrongful death occurring on or after October 1, 1987, whether in tort or in contract, in which it is alleged that such injury or death resulted from the negligence of a health care provider, unless the attorney or party filing the action or apportionment complaint has made a reasonable inquiry as permitted by the circumstances to determine that there are grounds for a good faith belief that there has been negligence in the care or treatment of the claimant. The complaint, **[**or**]** initial pleading or apportionment complaint shall contain a certificate of the attorney or party filing the action or apportionment complaint that such reasonable inquiry gave rise to a good faith belief that grounds exist for an action against each named defendant or for an apportionment complaint against each named apportionment defendant. **[**For the purposes of this section, such good faith may be shown to exist if the claimant or his attorney has received a written opinion, which shall not be subject to discovery by any party except for questioning the validity of the certificate,**]** To show the existence of such good faith, the claimant or such claimant's attorney, and any apportionment complainant or such apportionment complainant's attorney, shall obtain a written and signed opinion of a similar health care provider, as defined in section 52-184c, which similar health care provider shall be selected pursuant to the provisions of said section, that there appears to be evidence of medical negligence and includes a detailed basis for the formation of such opinion. Such written opinion shall not be subject to discovery by any party except for questioning the validity of the certificate. The claimant or such claimant's attorney, and any

apportionment complainant or such apportionment complainant's attorney, shall retain the original written opinion and shall attach a copy of such written opinion, with the name and signature of the similar health care provider expunged, to such certificate. The similar health care provider who provides such written opinion shall not, without a showing of malice, be personally liable for any damages to the defendant health care provider by reason of having provided such written opinion. In addition to such written opinion, the court may consider other factors with regard to the existence of good faith. If the court determines, after the completion of discovery, that such certificate was not made in good faith and that no justiciable issue was presented against a health care provider that fully cooperated in providing informal discovery, the court upon motion or upon its own initiative shall impose upon the person who signed such certificate or a represented party, or both, an appropriate sanction which may include an order to pay to the other party or parties the amount of the reasonable expenses incurred because of the filing of the pleading, motion or other paper, including a reasonable attorney's fee. The court may also submit the matter to the appropriate authority for disciplinary review of the attorney if the claimant's attorney or apportionment complainant's attorney submitted the certificate.

(b) If a claimant in a civil action asserts a claim against an apportionment defendant pursuant to subsection (d) of section 52-102b, the requirement under subsection (a) of this section that the attorney or party filing the action make a reasonable inquiry and submit a certificate of good faith shall be satisfied by the submission of a certificate of good faith by the apportionment complainant pursuant to subsection (a) of this section.

[(b)**]** (c) Upon petition to the clerk of the court where the action will be filed, an automatic ninety-day extension of the statute of limitations shall be granted to allow the reasonable inquiry required by subsection (a) of this section. This period shall be in addition to other tolling periods.

Sec. 3. Section 52-192a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) After commencement of any civil action based upon contract or seeking the recovery of money damages, whether or not other relief is sought, the plaintiff may, not later than thirty days before trial, file with the clerk of the court a written "offer of judgment" signed by the plaintiff or the plaintiff's attorney, directed to the defendant or the defendant's attorney, offering to settle the claim underlying the action and to stipulate to a judgment for a sum certain. The plaintiff shall give notice of the offer of settlement to the defendant's attorney or, if the defendant is not represented by an attorney, to the defendant himself or herself. Within sixty days after being notified of the filing of the "offer of judgment" or within any extension or extensions thereof, not to exceed a total of one hundred twenty additional days, granted by the court for good cause shown not later than the expiration of such sixty-day period or any extension thereof, and prior to the rendering of a verdict by the jury or an award by the court, the defendant or the defendant's attorney may file with the clerk of the court a written "acceptance of offer of judgment" agreeing to a stipulation for judgment as contained in plaintiff's "offer of judgment". Upon such filing, the clerk shall enter judgment immediately on the stipulation. If the "offer of judgment" is not accepted within **[**sixty days**]** the sixty-day period or any extension thereof, and prior to the rendering of a verdict by the jury or an award by the court, the "offer of judgment" shall be considered rejected and not subject to acceptance unless refiled. Any such "offer of judgment" and any "acceptance of offer of judgment" shall be included by the clerk in the record of the case.

(b) After trial the court shall examine the record to determine whether the plaintiff made an "offer of judgment" which the defendant failed to accept. **[**If**]** Except with respect to a civil action described in subsection (c) of this section, if the court ascertains from the record that the plaintiff has recovered an amount equal to or greater than the sum certain stated in the plaintiff's "offer of judgment", the court shall add

to the amount so recovered twelve per cent annual interest on said amount. [, computed from the date such offer was filed in actions commenced before October 1, 1981. In those actions commenced on or after October 1, 1981, the]

(c) With respect to any civil action brought to recover damages resulting from personal injury or wrongful death, whether in tort or in contract, in which it is alleged that such injury or death resulted from the negligence of a health care provider, and where the cause of action accrued on or after the effective date of this section, if the court ascertains from the record that the plaintiff has recovered an amount equal to or greater than the sum certain stated in the plaintiff's offer of judgment, the court shall add to the amount so recovered eight per cent annual interest on said amount, except that if the plaintiff has recovered an amount that is more than twice the sum certain stated in the plaintiff's offer of judgment, the court shall add to the amount so recovered (1) eight per cent annual interest on the portion of the amount recovered that is equal to or less than twice the sum certain stated in such offer of judgment, and (2) four per cent annual interest on the portion of the amount recovered that is more than twice the sum certain stated in such offer. For the purposes of this subsection, "health care provider" means a provider, as defined in subsection (b) of section 20-7b, or an institution, as defined in section 19a-490.

(d) The interest shall be computed from the date the complaint in the civil action was filed with the court if the "offer of judgment" was filed not later than eighteen months from the filing of such complaint. If such offer was filed later than eighteen months from the date of filing of the complaint, the interest shall be computed from the date the "offer of judgment" was filed. The court may award reasonable attorney's fees in an amount not to exceed three hundred fifty dollars, and shall render judgment accordingly. This section shall not be interpreted to abrogate the contractual rights of any party concerning the recovery of attorney's fees in accordance with the provisions of any written contract between the parties to the action.

Sec. 4. Section 52-194 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

In any action, the plaintiff may, within **[**ten**]** sixty days after being notified by the defendant of the filing of an offer of judgment, or within any extension or extensions thereof, not to exceed a total of one hundred twenty additional days, granted by the court for good cause shown not later than the expiration of such sixty-day period or any extension thereof, file with the clerk of the court a written acceptance of the offer signed by **[**himself or his**]** the plaintiff or the plaintiff's attorney. Upon the filing of the written acceptance, the court shall render judgment against the defendant as upon default for the sum so named and for the costs accrued at the time of the defendant's giving the plaintiff notice of the offer. No trial may be postponed because the period within which the plaintiff may accept the offer has not expired, except at the discretion of the court.

Sec. 5. Section 52-251c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage and applicable to causes of action accruing on or after said date*):

(a) In any claim or civil action to recover damages resulting from personal injury, wrongful death or damage to property occurring on or after October 1, 1987, the attorney and the claimant may provide by contract, which contract shall comply with all applicable provisions of the rules of professional conduct governing attorneys adopted by the judges of the Superior Court, that the fee for the attorney shall be paid contingent upon, and as a percentage of: (1) Damages awarded and received by the claimant; or (2) the settlement amount received pursuant to a settlement agreement.

(b) In any such contingency fee arrangement such fee shall be the exclusive method for payment of the attorney by the claimant and shall not exceed an amount equal to a percentage of the damages awarded and received by the claimant or of the settlement amount received by the claimant as follows: (1) Thirty-three and one-third per

cent of the first three hundred thousand dollars; (2) twenty-five per cent of the next three hundred thousand dollars; (3) twenty per cent of the next three hundred thousand dollars; (4) fifteen per cent of the next three hundred thousand dollars; and (5) ten per cent of any amount which exceeds one million two hundred thousand dollars.

(c) (1) Whenever a claimant in a medical malpractice claim or civil action enters into a contingency fee arrangement with an attorney which provides for a fee that would exceed the percentage limitations set forth in subsection (b) of this section, such fee arrangement shall not be valid unless the claimant's attorney files an application with the court for approval of such fee arrangement and the court, after a hearing, grants such application. The claimant's attorney shall attach to such application a copy of such fee arrangement and the proposed unsigned writ, summons and complaint. Such fee arrangement shall provide that the attorney will advance all costs in connection with the investigation and prosecution or settlement of the medical malpractice claim or civil action and the claimant will not be liable for the reimbursement of the attorney for any such costs if there is no recovery.

(2) At the hearing required under subdivision (1) of this subsection, the court shall address the claimant personally to determine if the claimant understands his or her rights under subsection (b) of this section and has knowingly and voluntarily waived such rights. The court shall grant such application if it finds that the claimant has knowingly and voluntarily waived such rights and that the medical malpractice claim or civil action is so substantially complex, unique or different from other medical malpractice claims or civil actions as to warrant a deviation from such percentage limitations. The claimant's attorney shall have the burden of showing at the hearing that such deviation is warranted. In no event shall the court grant an application approving a fee arrangement that provides for a fee that exceeds an amount equal to thirty-three and one-third per cent of the damages awarded and received by the claimant or of the settlement amount

received by the claimant. If the court denies the application, the court shall advise the claimant of the claimant's right to seek representation by another attorney willing to abide by the percentage limitations set forth in subsection (b) of this section. Only one application may be filed under this subsection with respect to the claimant and the claimant's medical malpractice claim or civil action.

(3) The filing of such application shall toll the applicable statute of limitations until ninety days after the court's decision to grant or deny the application. The decision of the court to grant or deny the application shall not be subject to appeal. The Chief Court Administrator shall assign a judge or judges with experience in personal injury claims or civil actions to hear and determine applications filed under this subsection. A transcript of the hearing shall be prepared, and such transcript shall be sealed and available for the use of the court only.

(d) If the attorney makes disbursements or incurs costs in connection with the investigation and prosecution or settlement of the claim or civil action for which the claimant is liable, in no event shall the claimant be required to pay interest on the amount of such disbursements and costs.

[(c) For**]** (e) (1) Except as provided in subdivision (2) of this subsection, for the purposes of this section, "damages awarded and received" means in a civil action in which final judgment is entered, that amount of the judgment or amended judgment entered by the court that is received by the claimant; **[**, except that in a civil action brought pursuant to section 38a-368 such amount shall be reduced by any basic reparations benefits paid to the claimant pursuant to section 38a-365;**]** "settlement amount received" means in a claim or civil action in which no final judgment is entered, the amount received by the claimant pursuant to a settlement agreement; **[**, except that in a claim or civil action brought pursuant to section 38a-368 such amount shall be reduced by any basic reparations benefits paid to the claimant

pursuant to section 38a-365;**]** and "fee" shall not include disbursements or costs incurred in connection with the prosecution or settlement of the claim or civil action, other than ordinary office overhead and expense.

(2) For the purposes of this section with respect to a medical malpractice claim or civil action in which an application was granted by a court pursuant to subsection (c) of this section, "damages awarded and received" means in a civil action in which final judgment is entered, that amount of the judgment or amended judgment entered by the court that is received by the claimant after deduction for any disbursements made or costs incurred by the attorney in connection with the investigation and prosecution or settlement of the civil action, other than ordinary office overhead and expense, for which the claimant is liable; and "settlement amount received" means in a claim or civil action in which no final judgment is entered, the amount received by the claimant pursuant to a settlement agreement after deduction for any disbursements made or costs incurred by the attorney in connection with the investigation and prosecution or settlement of the claim or civil action, other than ordinary office overhead and expense, for which the claimant is liable.

[(d)**]** (f) For the purposes of this section, "medical malpractice claim or civil action" means a claim or civil action brought to recover damages resulting from personal injury or wrongful death, whether in tort or in contract, in which it is alleged that such injury or death resulted from the negligence of a health care provider, and "health care provider" means a provider, as defined in subsection (b) of section 20-7b, or an institution, as defined in section 19a-490.

Sec. 6. (NEW) (*Effective from passage*) Whenever in a civil action to recover damages resulting from personal injury or wrongful death, whether in tort or in contract, in which it is alleged that such injury or death resulted from the negligence of a health care provider, the jury renders a verdict specifying noneconomic damages, as defined in

section 52-572h of the general statutes, in an amount exceeding one million dollars, the court shall review the evidence presented to the jury to determine if the amount of noneconomic damages specified in the verdict is excessive as a matter of law in that it so shocks the sense of justice as to compel the conclusion that the jury was influenced by partiality, prejudice, mistake or corruption. If the court so concludes, it shall order a remittitur and, upon failure of the party so ordered to remit the amount ordered by the court, it shall set aside the verdict and order a new trial. For the purposes of this section, "health care provider" means a provider, as defined in subsection (b) of section 20-7b of the general statutes, or an institution, as defined in section 19a-490 of the general statutes.

Sec. 7. Section 19a-17a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Upon the filing of any civil action regarding a medical malpractice claim against an individual licensed pursuant to chapter 370 to 373, inclusive, 375, 379, 380 or 383, the plaintiff or the plaintiff's attorney shall mail a copy of the complaint to the Department of Public Health and the Insurance Department. Receipt or review of a copy of a complaint submitted pursuant to this subsection shall not be considered an investigation of such individual licensee by the Department of Public Health or any examining board.

(b) Upon entry of any medical malpractice award by a court or upon the parties entering a settlement of a malpractice claim against an individual licensed pursuant to chapter 370 to 373, inclusive, 375, 379, 380 or 383, the entity making payment on behalf of a party or, if no such entity exists, the party, shall **[**notify**]** provide to the Department of Public Health and the Insurance Department notice of the terms of the award or settlement and **[**shall provide to the department**]** a copy of the award or settlement and the underlying complaint and answer, if any. Such notice and copies provided to the Insurance Department shall not identify the parties to the claim. The Department of Public

Health shall send the information received from such entity or party to the state board of examiners having cognizance over any individual licensed pursuant to chapter 370 to 373, inclusive, 375, 379, 380 or 383 who is a party to the claim. The **[**department**]** Department of Public Health shall review all medical malpractice complaints, awards and **[**all**]** settlements to determine whether further investigation or disciplinary action against the providers involved is warranted. On and after October 1, 2005, such review shall be conducted in accordance with the guidelines adopted by the Department of Public Health, in accordance with section 20-13b, as amended by this act, to determine the basis for such further investigation or disciplinary action. Any document received pursuant to this section shall not be considered a petition and shall not be subject to **[**the provisions of**]** disclosure under section 1-210 unless the **[**department**]** Department of Public Health determines, following completion of its review, that further investigation or disciplinary action is warranted. As used in this subsection, "terms of the award or settlement" means the rights and obligations of the parties to a medical malpractice claim, as determined by a court or by agreement of the parties, and includes, but is not limited to, (1) for any individual licensed pursuant to chapter 370 to 373, inclusive, 375, 379, 380 or 383 who is a party to the claim, the type of healing art or other health care practice, and the specialty, if any, in which such individual engages, (2) the amount of the award or settlement, specifying the portion of the award or settlement attributable to economic damages, the portion of the award or settlement attributable, if determined by the parties, to noneconomic damages, and, if an award was entered, the portion of the award, if any, attributable to interest awarded pursuant to section 52-192a, as amended by this act, and (3) if there are multiple defendants, the allocation for payment of the award or settlement between or among such defendants.

(c) No release of liability executed by a party to which payment is to be made under a settlement of a malpractice claim against an

individual licensed pursuant to chapter 370 to 373, inclusive, 375, 379, 380 or 383 shall be effective until the attorney for the entity making payment on behalf of a party or, if no such entity exists, the attorney for the party, files with the court an affidavit stating that such attorney has provided the information required under subsection (b) of this section to the Department of Public Health and the Insurance Department.

(d) The Commissioner of Public Health and the Insurance Commissioner shall each develop a system within the commissioner's respective agency for collecting, storing, utilizing, interpreting, reporting and providing public access to the information received under subsections (a) and (b) of this section. Each commissioner shall report the details of such system with respect to the commissioner's agency to the joint standing committees of the General Assembly having cognizance of matters relating to public health and insurance on or before October 1, 2005, in accordance with section 11-4a.

Sec. 8. Subsection (b) of section 19a-88 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) Each person holding a license to practice medicine, surgery, podiatry, chiropractic or natureopathy shall, annually, during the month of such person's birth, register with the Department of Public Health, upon payment of the professional services fee for class I, as defined in section 33-182*l*, on blanks to be furnished by the department for such purpose, giving such person's name in full, such person's residence and business address, the name of the insurance company providing such person's professional liability insurance and the policy number of such insurance, such person's area of specialization, whether such person is actively involved in patient care, any disciplinary action against such person, or malpractice payments made on behalf of such person in any other state or jurisdiction, and such other information as the department requests. The department may

compare information submitted pursuant to this subsection to information contained in the National Practitioner Data Base. Persons may fulfill their obligation to report the information required by this subsection by submitting such information as part of their physician profile, in accordance with section 20-13j. The department shall revise any forms utilized pursuant to section 20-13j to incorporate any additional information required pursuant to this subsection.

Sec. 9. Section 20-8a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) There shall be within the Department of Public Health a Connecticut Medical Examining Board. Said board shall consist of fifteen members appointed by the Governor, subject to the provisions of section 4-9a, in the manner prescribed for department heads in section 4-7, as follows: Five physicians practicing in the state; one physician who shall be a full-time member of the faculty of The University of Connecticut School of Medicine; one physician who shall be a full-time chief of staff in a general-care hospital in the state; one physician who shall be registered as a supervising physician for one or more physician assistants; one physician who shall be a graduate of a medical education program accredited by the American Osteopathic Association; one physician assistant licensed pursuant to section 20-12b and practicing in this state; and five public members. No professional member of said board shall be an elected or appointed officer of a professional society or association relating to such member's profession at the time of appointment to the board or have been such an officer during the year immediately preceding appointment or serve for more than two consecutive terms. Professional members shall be practitioners in good professional standing and residents of this state.

(b) All vacancies shall be filled by the Governor in the manner prescribed for department heads in section 4-7. Successors and appointments to fill a vacancy shall fulfill the same qualifications as

the member succeeded or replaced. In addition to the requirements in sections 4-9a and 19a-8, no person whose spouse, parent, brother, sister, child or spouse of a child is a physician, as defined in section 20-13a, or a physician assistant, as defined in section 20-12a, shall be appointed as a public member.

(c) The Commissioner of Public Health shall establish a list of eighteen persons who may serve as members of medical hearing panels established pursuant to **[**subsection (g) of**]** this section. Persons appointed to the list shall serve as members of the medical hearing panels and provide the same services as members of the Connecticut Medical Examining Board. Members from the list serving on such panels shall not be voting members of the Connecticut Medical Examining Board. The list shall consist of eighteen members appointed by the commissioner, eight of whom shall be physicians, as defined in section 20-13a, with at least one of such physicians being a graduate of a medical education program accredited by the American Osteopathic Association, one of whom shall be a physician assistant licensed pursuant to section 20-12b, and nine of whom shall be members of the public. No professional member of the list shall be an elected or appointed officer of a professional society or association relating to such member's profession at the time of appointment to the list or have been such an officer during the year immediately preceding such appointment to the list. A licensed professional appointed to the list shall be a practitioner in good professional standing and a resident of this state. All vacancies shall be filled by the commissioner. Successors and appointments to fill a vacancy on the list shall possess the same qualifications as those required of the member succeeded or replaced. No person whose spouse, parent, brother, sister, child or spouse of a child is a physician, as defined in section 20-13a, or a physician assistant, as defined in section 20-12a, shall be appointed to the list as a member of the public. Each person appointed to the list shall serve without compensation at the pleasure of the commissioner. Each medical hearing panel shall consist of three members, one of whom shall be a similar health care provider, as defined in section 52-184c, to

the person who is the subject of the complaint, and two of whom shall be public members. At least one of the three members shall be a member of the Connecticut Medical Examining Board. The public members may be a member of the board or a member from the list established pursuant to this subsection.

(d) The office of the board shall be in Hartford, in facilities to be provided by the department.

(e) The board shall adopt and may amend a seal.

(f) The Governor shall appoint a chairperson from among the board members. Said board shall meet at least once during each calendar quarter and at such other times as the chairperson deems necessary. Special meetings shall be held on the request of a majority of the board after notice in accordance with the provisions of section 1-225. A majority of the members of the board shall constitute a quorum. Members shall not be compensated for their services. Any member who fails to attend three consecutive meetings or who fails to attend fifty per cent of all meetings held during any calendar year shall be deemed to have resigned from office. Minutes of all meetings shall be recorded by the board. No member shall participate in the affairs of the board during the pendency of any disciplinary proceedings by the board against such member. Said board shall (1) hear and decide matters concerning suspension or revocation of licensure, (2) adjudicate complaints against practitioners, and (3) impose sanctions where appropriate.

(g) (1) Not later than July 1, 2005, the board, with the assistance of the department, shall adopt regulations, in accordance with chapter 54, to establish guidelines for use in the disciplinary process. Such guidelines shall include, but need not be limited to: (A) Identification of each type of violation; (B) a range of penalties for each type of violation; (C) additional optional conditions that may be imposed by the board for each violation; (D) identification of factors the board shall consider in determining what penalty should apply; (E) conditions,

such as mitigating factors or other facts, that may be considered in allowing deviations from the guidelines; and (F) a provision that when a deviation from the guidelines occurs, the reason for the deviation shall be identified and included as part of the record.

(2) The board shall refer all statements of charges filed with the board by the department pursuant to section 20-13e, as amended by this act, to a medical hearing panel **[**within**]** not later than sixty days **[**of**]** after the receipt of charges. **[**This**]** The time period may be extended for good cause by the board in a duly recorded vote. **[**The panel shall consist of three members, at least one of whom shall be a member of the board and one a member of the public. The public member may be a member of either the board or of the list established pursuant to subsection (c) of this section.**]** The panel shall conduct a hearing in accordance with the provisions of chapter 54, and the regulations **[**established**]** adopted by the Commissioner of Public Health concerning contested cases, except that the panel shall file a proposed final decision with the board **[**within**]** not later than one hundred twenty days **[**of**]** after the receipt of the issuance of the notice of hearing by the board. The time period for filing such proposed final decision with the board may be extended for good cause by the board in a duly recorded vote. If the panel does not conduct a hearing within sixty days of the date of referral of the statement of charges by the board, the commissioner shall conduct a hearing in accordance with chapter 54 and the regulations adopted by the commissioner concerning contested cases. The commissioner shall file a proposed final decision with the board not later than sixty days after such hearing, except that the time period for filing such proposed final decision with the board may be extended for good cause by the board in a duly recorded vote.

(h) The board shall review the panel's proposed final decision in accordance with the provisions of section 4-179, and adopt, modify or remand said decision for further review or for the taking of additional evidence. The board shall act on the proposed final decision **[**within**]**

not later than ninety days [of] after the filing of said decision by the panel. [This] The time period may be extended by the board for good cause in a duly recorded vote.

(i) Except in a case in which a license has been summarily suspended, pursuant to subsection (c) of section 19a-17 or subsection (c) of section 4-182, all three panel members shall be present to hear any evidence and vote on a proposed final decision. The chairperson of the Medical Examining Board may exempt a member from a meeting of the panel if the chairperson finds that good cause exists for such an exemption. Such an exemption may be granted orally but shall be reduced to writing and included as part of the record of the panel within two business days of the granting of the exemption or the opening of the record and shall state the reason for the exemption. Such exemption shall be granted to a member no more than once during any contested case and shall not be granted for a meeting at which the panel is acting on a proposed final decision on a statement of charges. The board may appoint a member to the panel to replace any member who resigns or otherwise fails to continue to serve on the panel. Such replacement member shall review the record prior to the next hearing.

(j) A determination of good cause shall not be reviewable and shall not constitute a basis for appeal of the decision of the board pursuant to section 4-183.

Sec. 10. Section 20-13b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

The Commissioner of Public Health, with advice and assistance from the board, may establish such regulations in accordance with chapter 54 as may be necessary to carry out the provisions of sections 20-13a to 20-13i, inclusive, as amended by this act. On or before July 1, 2005, such regulations shall include, but need not be limited to: (1) Guidelines for screening complaints received to determine which complaints will be investigated; (2) guidelines to provide a basis for

prioritizing the order in which complaints will be investigated; (3) a system for conducting investigations to ensure prompt action when it appears necessary; (4) guidelines to determine when an investigation should be broadened beyond the scope of the initial complaint to include sampling patient records to identify patterns of care, reviewing office practices and procedures, reviewing performance and discharge data from hospitals and managed care organizations and conducting additional interviews of patients; and (5) guidelines to protect and ensure the confidentiality of patient and provider identifiable information when an investigation is broadened beyond the scope of the initial complaint.

Sec. 11. Subsection (a) of section 20-13e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) (1) The department shall investigate each petition filed pursuant to section 20-13d, in accordance with the provisions of subdivision (10) of subsection (a) of section 19a-14 to determine if probable cause exists to issue a statement of charges and to institute proceedings against the physician under subsection (e) of this section. Such investigation shall be concluded not later than eighteen months from the date the petition is filed with the department and, unless otherwise specified by this subsection, the record of such investigation shall be deemed a public record, in accordance with section 1-210, at the conclusion of such eighteen-month period. Any such investigation shall be confidential and no person shall disclose his knowledge of such investigation to a third party unless the physician requests that such investigation and disclosure be open. If the department determines that probable cause exists to issue a statement of charges, the entire record of such proceeding shall be public unless the department determines that the physician is an appropriate candidate for participation in a rehabilitation program in accordance with subsection (b) of this section and the physician agrees to participate in such program in accordance with terms agreed upon by the department and the physician. If at any

time subsequent to the filing of a petition and during the eighteen-month period, the department makes a finding of no probable cause, the petition and the entire record of such investigation shall remain confidential unless the physician requests that such petition and record be open.

(2) If the department makes a finding of no probable cause, it shall notify the person who filed the petition or such person's personal representative and the physician of such finding and the reasons for such finding.

Sec. 12. Section 20-13i of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

The department shall file with the Governor and the joint standing committee **[**on public health**]** of the General Assembly having cognizance of matters relating to public health on or before January 1, 1986, and thereafter on or before January first of each succeeding year, a report of the activities of the department and the board conducted pursuant to sections 20-13d and 20-13e, as amended by this act. Each such report shall include, but shall not be limited to, the following information: The number of petitions received; the number of petitions not investigated, and the reasons why; the number of hearings held on such petitions; **[**and,**]** the outcome of such hearings; the timeliness of action taken on any petition considered to be a priority; without identifying the particular physician concerned, a brief description of the impairment alleged in each such petition and the actions taken with regard to each such petition by the department and the board; the number of notifications received pursuant to section 19a-17a, as amended by this act; the number of such notifications with no further action taken, and the reasons why; and the outcomes for notifications where further action is taken.

Sec. 13. (NEW) (*Effective from passage*) (a) The Department of Public Health shall develop protocols for accurate identification procedures that shall be used by hospitals and outpatient surgical facilities prior to

surgery. Such protocols shall include, but need not be limited to, (1) procedures to be followed to identify the (A) patient, (B) surgical procedure to be performed, and (C) body part on which the surgical procedure is to be performed, and (2) alternative identification procedures in urgent or emergency circumstances or where the patient is nonspeaking, comatose or incompetent or is a child. After October 1, 2005, no hospital or outpatient surgical facility may anesthetize a patient or perform surgery unless the protocols have been followed.

(b) Not later than October 1, 2005, the department shall report, in accordance with section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health describing the protocols developed pursuant to subsection (a) of this section.

Sec. 14. (NEW) (*Effective from passage*) On or before January 1, 2006, and annually thereafter, the Department of Public Health shall report, in accordance with section 11-4a of the general statutes, the number of physicians by specialty who are actively providing patient care.

Sec. 15. (NEW) (*Effective from passage*) (a) The Commissioner of Public Health shall develop and implement a process to ensure a continuing and coordinated focus on patient safety programs within the Department of Public Health. Such process shall encompass activities undertaken by the department to (1) coordinate state initiatives on patient safety, (2) facilitate ongoing collaborations between the public and private sectors, (3) promote patient safety through education of health care providers and patients, (4) assure coordination in collecting, analyzing and responding to adverse events reports submitted to the department pursuant to section 19a-127n of the general statutes, (5) coordinate state and federal patient safety programs, (6) participate in the federal Patient Safety Improvement Corps to identify the causes of medical errors, and (7) promote the recommendations of the Quality of Care Advisory Committee established in section 19a-127*l* of the general statutes.

(b) On or before January 1, 2006, and annually thereafter, the Commissioner of Public Health shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the Governor and the chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health, providing a description of the process developed pursuant to subsection (a) of this section, an analysis of its operation and impact with respect to the activities enumerated in subsection (a) of this section, a description of the activities undertaken by the department's patient safety programs, and recommendations for future action.

Sec. 16. Section 38a-25 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The Insurance Commissioner is the agent for receipt of service of legal process on the following:

(1) Foreign and alien insurance companies authorized to do business in this state in any proceeding arising from or related to any transaction having a connection with this state.

(2) Fraternal benefit societies authorized to do business in this state.

(3) Insurance-support organizations as defined in section 38a-976, transacting business outside this state which affects a resident of this state.

(4) Risk retention groups**,** **[**designating the Insurance Commissioner as agent for receipt of service of process pursuant to section 38a-252**]** as defined in section 38a-250.

(5) Purchasing groups designating the Insurance Commissioner as agent for receipt of service of process pursuant to section 38a-261.

(6) Eligible surplus lines insurers authorized by the commissioner to accept surplus lines insurance.

(7) Except as provided by section 38a-273, unauthorized insurers or other persons assisting unauthorized insurers who directly or indirectly do any of the acts of insurance business as set forth in subsection (a) of section 38a-271.

(8) The Connecticut Insurance Guaranty Association and the Connecticut Life and Health Insurance Guaranty Association.

(9) Insurance companies designating the Insurance Commissioner as agent for receipt of service of process pursuant to subsection (g) of section 38a-85.

(10) Nonresident insurance producers and nonresident surplus lines brokers licensed by the Insurance Commissioner.

(11) Viatical settlement providers, viatical settlement brokers, and viatical settlement investment agents licensed by the commissioner.

(12) Nonresident reinsurance intermediaries designating the commissioner as agent for receipt of service of process pursuant to section 38a-760b.

(13) Workers' compensation self-insurance groups, as defined in section 38a-1001.

(14) Persons alleged to have violated any provision of section 38a-130.

(15) Captive insurers, as defined in section 17 of this act.

(b) Each foreign and alien insurer by applying for and receiving a license to do insurance business in this state, each fraternal benefit society by applying for and receiving a certificate to solicit members and do business, each surplus lines insurer declared to be an eligible surplus lines insurer by the commissioner, each insurance-support organization transacting business outside this state which affects a resident of this state, and each unauthorized insurer by doing an act of

insurance business prohibited by section 38a-272, is considered to have irrevocably appointed the Insurance Commissioner as **[**his**]** agent for receipt of service of process in accordance with subsection (a) of this section. Such appointment shall continue in force so long as any certificate of membership, policy or liability remains outstanding in this state.

(c) The commissioner is also agent for the executors, administrators or personal representatives, receivers, trustees or other successors in interest of the persons specified under subsection (a) of this section.

(d) Any legal process that is served on the commissioner pursuant to this section shall be of the same legal force and validity as if served on the principal.

(e) The right to effect service of process as provided under this section does not limit the right to serve legal process in any other manner provided by law.

Sec. 17. (NEW) (*Effective July 1, 2005*) Each captive insurer that offers, renews or continues insurance in this state shall provide the information described in subdivisions (1) to (3), inclusive, of subsection (a) of section 38a-253 of the general statutes to the Insurance Commissioner in the same manner required for risk retention groups. If a captive insurer does not maintain information in the form prescribed in section 38a-253 of the general statutes, the captive insurer may submit the information to the Insurance Commissioner on such form as the commissioner prescribes. As used in this section and section 38a-25 of the general statutes, as amended by this act, "captive insurer" means an insurance company owned by another organization whose primary purpose is to insure risks of a parent organization or affiliated persons, as defined in section 38a-1 of the general statutes, or in the case of groups and associations, an insurance organization owned by the insureds whose primary purpose is to insure risks of member organizations and group members and their affiliates.

Sec. 18. Section 38a-395 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2006*):

[The Insurance Commissioner may require all insurance companies writing medical malpractice insurance in this state to submit, in such manner and at such times as he specifies, such information as he deems necessary to establish a data base on medical malpractice, including information on all incidents of medical malpractice, all settlements, all awards, other information relative to procedures and specialties involved and any other information relating to risk management.**]**

(a) As used in this section:

(1) "Claim" means a request for indemnification filed by a physician, surgeon, hospital, advanced practice registered nurse or physician assistant pursuant to a professional liability policy for a loss for which a reserve amount has been established by an insurer;

(2) "Closed claim" means a claim that has been settled, or otherwise disposed of, where the insurer has made all indemnity and expense payments on the claim; and

(3) "Insurer" means an insurer that insures a physician, surgeon, hospital, advanced practice registered nurse or physician assistant against professional liability. "Insurer" includes, but is not limited to, a captive insurer or a self-insured person.

(b) On and after January 1, 2006, each insurer shall provide to the Insurance Commissioner a closed claim report, on such form as the commissioner prescribes, in accordance with this section. The insurer shall submit the report not later than ten days after the last day of the calendar quarter in which a claim is closed. The report shall only include information about claims settled under the laws of this state.

(c) The closed claim report shall include:

(1) Details about the insured and insurer, including: (A) The name of the insurer; (B) the professional liability insurance policy limits and whether the policy was an occurrence policy or was issued on a claims-made basis; (C) the name, address, health care provider professional license number and specialty coverage of the insured; and (D) the insured's policy number and a unique claim number.

(2) Details about the injury or loss, including: (A) The date of the injury or loss that was the basis of the claim; (B) the date the injury or loss was reported to the insurer; (C) the name of the institution or location at which the injury or loss occurred; (D) the type of injury or loss, including a severity of injury rating that corresponds with the severity of injury scale that the Insurance Commissioner shall establish based on the severity of injury scale developed by the National Association of Insurance Commissioners; and (E) the name, age and gender of any injured person covered by the claim. Any individually identifiable health information, as defined in 45 CFR 160.103, as from time to time amended, submitted pursuant to this subdivision shall be confidential. The reporting of the information is required by law. If necessary to comply with federal privacy laws, including the Health Insurance Portability and Accountability Act of 1996, (P.L. 104-191) (HIPAA), as from time to time amended, the insured shall arrange with the insurer to release the required information.

(3) Details about the claims process, including: (A) Whether a lawsuit was filed, and if so, in which court; (B) the outcome of such lawsuit; (C) the number of other defendants, if any; (D) the stage in the process when the claim was closed; (E) the dates of the trial, if any; (F) the date of the judgment or settlement, if any; (G) whether an appeal was filed, and if so, the date filed; (H) the resolution of any appeal and the date such appeal was decided; (I) the date the claim was closed; (J) the initial indemnity and expense reserve for the claim; and (K) the final indemnity and expense reserve for the claim.

(4) Details about the amount paid on the claim, including: (A) The

total amount of the initial judgment rendered by a jury or awarded by the court; (B) the total amount of the settlement if there was no judgment rendered or awarded; (C) the total amount of the settlement if the claim was settled after judgment was rendered or awarded; (D) the amount of economic damages, as defined in section 52-572h, or the insurer's estimate of the amount in the event of a settlement; (E) the amount of noneconomic damages, as defined in section 52-572h, or the insurer's estimate of the amount in the event of a settlement; (F) the amount of any interest awarded due to failure to accept an offer of judgment; (G) the amount of any remittitur or additur; (H) the amount of final judgment after remittitur or additur; (I) the amount paid by the insurer; (J) the amount paid by the defendant due to a deductible or a judgment or settlement in excess of policy limits; (K) the amount paid by other insurers; (L) the amount paid by other defendants; (M) whether a structured settlement was used; (N) the expense assigned to and recorded with the claim, including, but not limited to, defense and investigation costs, but not including the actual claim payment; and (O) any other information the commissioner determines to be necessary to regulate the professional liability insurance industry with respect to physicians, surgeons, hospitals, advanced practice registered nurses or physician assistants, ensure the industry's solvency and ensure that such liability insurance is available and affordable.

(d) (1) The commissioner shall establish an electronic database composed of closed claim reports filed pursuant to this section.

(2) The commissioner shall compile the data included in individual closed claim reports into an aggregated summary format and shall prepare a written annual report of the summary data. The report shall provide an analysis of closed claim information including a minimum of five years of comparative data, when available, trends in frequency and severity of claims, itemization of damages, timeliness of the claims process, and any other descriptive or analytical information that would assist in interpreting the trends in closed claims.

(3) The annual report shall include a summary of rate filings for professional liability insurance for physicians, surgeons, hospitals, advanced practice registered nurses and physician assistants, which have been approved by the department for the prior calendar year, including an analysis of the trend of direct losses, incurred losses, earned premiums and investment income as compared to prior years. The report shall include base premiums charged by insurers for each specialty and the number of providers insured by specialty for each insurer.

(4) Not later than March 15, 2007, and annually thereafter, the commissioner shall submit the annual report to the joint standing committee of the General Assembly having cognizance of matters relating to insurance in accordance with section 11-4a. The commissioner shall also (A) make the report available to the public, (B) post the report on its Internet site, and (C) provide public access to the contents of the electronic database after the commissioner establishes that the names and other individually identifiable information about the claimant and practitioner have been removed.

(e) The Insurance Commissioner shall provide the Commissioner of Public Health with electronic access to all information received pursuant to this section. The Commissioner of Public Health shall maintain the confidentiality of such information in the same manner and to the same extent as required for the Insurance Commissioner.

Sec. 19. Section 38a-665 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

The following standards, methods and criteria shall apply to the making and use of rates pertaining to commercial risk insurance:

(a) Rates shall not be excessive or inadequate, as **[**herein**]** defined in this section, nor shall **[**they**]** rates be unfairly discriminatory. No rate shall be held to be excessive unless (1) such rate is unreasonably high for the insurance provided, or (2) a reasonable degree of competition

does not exist in the area with respect to the classification to which such rate is applicable. No rate shall be held inadequate unless (A) it is unreasonably low for the insurance provided, and (B) continued use **[**of it**]** would endanger solvency of the insurer, or unless (C) such rate is unreasonably low for the insurance provided and the use of such rate by the insurer **[**using same has, or, if continued,**]** has, or if continued will have, the effect of destroying competition or creating a monopoly.

(b) (1) Consideration shall be given, to the extent possible, to past and prospective loss experience within and outside this state, to conflagration and catastrophe hazards, to a reasonable margin for underwriting profit and contingencies, to past and prospective expenses both country-wide and those specially applicable to this state, to investment income earned or realized by insurers both from their unearned premium and loss reserve funds, and to all other factors, including judgment factors, deemed relevant within and outside this state and in the case of fire insurance rates, consideration may be given to the experience of the fire insurance business during the most recent five-year period for which such experience is available. Consideration may be given in the making and use of rates to dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers.

(2) With respect to rates for professional liability insurance for physicians and surgeons, hospitals, advanced practice registered nurses or physician assistants, consideration shall be given in the making and use of such rates to relevant factors that may reduce such rates, including, but not limited to: (A) Amendments to the offer of judgment provisions in section 52-192a, as amended by this act, and section 52-194, as amended by this act, (B) the other provisions of this act, and (C) any reduction in risk from the use of electronic health record systems to establish and maintain patient records and verify patient treatment.

(c) The systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the operating methods of any such insurer or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof.

(d) Risks may be grouped by classifications for the establishment of rates and minimum premiums, provided no surcharge on any motor vehicle liability or physical damage insurance premium may be assigned for (1) any accident involving only property damage of one thousand dollars or less, **[**or**]** (2) the first accident involving only property damage of more than one thousand dollars which would otherwise result in a surcharge to the policy of the insured, within the experience period set forth in the insurer's safe driver classification plan, **[**or**]** (3) any violation of section 14-219, unless such violation results in the suspension or revocation of the operator's license under section 14-111b, **[**or**]** (4) less than three violations of section 14-218a within any one-year period, or (5) any accident caused by an operator other than the named insured, a relative residing in the named insured's household, or a person who customarily operates the insured vehicle. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which provide for recognition of variations in hazards or expense provisions or both. Such rating plans may include application of the judgment of the insurer and may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses.

(e) Each rating plan shall establish appropriate eligibility criteria for determining significant risks which are to qualify under the plan, provided all such plans shall include as an eligible significant risk the state of Connecticut or its instrumentalities. Rating plans which comply with the provisions of this subsection shall be deemed to produce rates **[**which**]** <u>that</u> are not unfairly discriminatory.

(f) Notwithstanding the provisions of subsections (a) to (e),

inclusive, of this section, no rate shall include [any] an adjustment designed to recover underwriting or operating losses incurred out-of-state.

(g) The commissioner may adopt regulations in accordance with the provisions of chapter 54 concerning rating plans to [effectuate] implement the provisions of this section.

Sec. 20. Section 38a-676 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) With respect to rates pertaining to commercial risk insurance, and subject to the provisions of subsection (b) of this section with respect to professional liability insurance described in subsection (b) of this section and workers' compensation and employers' liability insurance, on or before the effective date [thereof, every] of such rates, each admitted insurer shall submit to the Insurance Commissioner for the commissioner's information, except as to inland marine risks which by general custom of the business are not written according to manual rates or rating plans, [every] each manual of classifications, rules and rates, and [every] each minimum, class rate, rating plan, rating schedule and rating system and any modification of the foregoing which it uses. Such submission by a licensed rating organization of which an insurer is a member or subscriber shall be sufficient compliance with this section for any insurer maintaining membership or subscribership in such organization, to the extent that the insurer uses the manuals, minimums, class rates, rating plans, rating schedules, rating systems, policy or bond forms of such organization. The information shall be open to public inspection after its submission.

(b) (1) Each filing as described in subsection (a) of this section for workers' compensation or employers' liability insurance shall be on file with the Insurance Commissioner for a waiting period of thirty days before it becomes effective, which period may be extended by the commissioner for an additional period not to exceed thirty days if the

commissioner gives written notice within such waiting period to the insurer or rating organization which made the filing that the commissioner needs such additional time for the consideration of such filing. Upon written application by such insurer or rating organization, the commissioner may authorize a filing which the commissioner has reviewed to become effective before the expiration of the waiting period or any extension thereof. A filing shall be deemed to meet the requirements of sections 38a-663 to 38a-696, inclusive, as amended by this act, unless disapproved by the commissioner within the waiting period or any extension thereof. If, within the waiting period or any extension thereof, the commissioner finds that a filing does not meet the requirements of said sections, the commissioner shall send to the insurer or rating organization which made such filing written notice of disapproval of such filing, specifying therein in what respects the commissioner finds such filing fails to meet the requirements of said sections and stating that such filing shall not become effective. Such finding of the commissioner shall be subject to review as provided in section 38a-19.

(2) (A) Each filing as described in subsection (a) of this section for professional liability insurance for physicians and surgeons, hospitals, advanced practice registered nurses or physician assistants shall be subject to prior rate approval in accordance with this section. On and after the effective date of this section, each insurer or rating organization seeking to change its rates for such insurance shall (i) file a request for such change with the Insurance Commissioner, and (ii) send written notice of any request for an increase in rates to insureds who would be subject to the increase. Such request shall be filed and such notice, if applicable, shall be sent at least sixty days prior to the proposed effective date of the change. The notice to insureds of a request for an increase in rates shall indicate that the insured may request a public hearing by submitting a written request to the Insurance Commissioner not later than fifteen days after the date of the notice. Any request for an increase in rates under this subdivision shall be filed after notice is sent to insureds and shall indicate the date such

notice was sent.

(B) The insurer or rating organization shall demonstrate in the filing, to the satisfaction of the commissioner, that (i) (I) the insurer or rating organization offers a premium reduction or a separate reduced rating classification for insureds who submit proof to the insurer that the insured and its personnel will use an electronic health record system during the premium period to establish and maintain patient records and verify patient treatment, and (II) the premium or rate reduction reflects the reduction in risk related to the use of such system, or (ii) if the insurer or rating organization does not offer such premium or rate reduction, that there is no measurable reduction in risk related to the use of such system.

(C) The Insurance Commissioner shall review the filing and, with respect to a request for an increase in rates, shall (i) not approve, modify or deny the request until at least fifteen days after the date of notice as indicated in the filing, and (ii) hold a public hearing, if requested, on such increase prior to approving, modifying or denying the request. The Insurance Commissioner shall approve, modify or deny the filing not later than forty-five days after its receipt. Such finding of the commissioner shall be subject to review as provided in section 38a-19.

(c) The form of any insurance policy or contract the rates for which are subject to the provisions of sections 38a-663 to 38a-696, inclusive, as amended by this act, other than fidelity, surety or guaranty bonds, and the form of any endorsement modifying such insurance policy or contract, shall be filed with the Insurance Commissioner prior to its issuance. The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, establishing a procedure for review of such policy or contract. If at any time the commissioner finds that any such policy, contract or endorsement is not in accordance with such provisions or any other provision of law, the commissioner shall issue an order disapproving the issuance of such form and stating the

reasons for disapproval. The provisions of section 38a-19 shall apply to any such order issued by the commissioner.

Sec. 21. (NEW) (*Effective July 1, 2005, and applicable to taxable years commencing on or after January 1, 2005*) (a) Any resident of this state, as defined in subdivision (1) of subsection (a) of section 12-701 of the general statutes, as amended, who is a physician and who is subject to the tax imposed under chapter 229 of the general statutes for any taxable year shall be entitled to a credit in determining the amount of tax liability under said chapter, for a portion, as permitted by this section, of the amount of medical malpractice insurance premiums first becoming due and actually paid during such taxable year by such person in accordance with this section.

(b) The credit allowed under this section shall be equal to one hundred per cent of the amount by which the medical malpractice insurance premiums first becoming due and actually paid during such taxable year by such person exceed twenty-five per cent of the person's Connecticut taxable income, provided such credit shall not exceed an amount equal to fifteen per cent of such premiums.

(c) The credit may only be used to reduce such qualifying taxpayer's tax liability for the year for which such credit is applicable and shall not be used to reduce such tax liability to less than zero.

(d) The amount of tax due pursuant to sections 12-705 and 12-722 of the general statutes shall be calculated without regard to this credit.

(e) Any physician who has had, at any time, a judgment entered against him or her as a defendant in a civil action to recover damages for personal injury or wrongful death resulting from the acts or omissions of such physician in the medical diagnosis, care or treatment of a person shall not be entitled to a credit under this section.

Sec. 22. Sections 38a-32 to 38a-36, inclusive, of the general statutes are repealed. (*Effective from passage*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	New section
Sec. 2	*from passage and applicable to actions filed on or after said date*	52-190a
Sec. 3	*from passage*	52-192a
Sec. 4	*from passage*	52-194
Sec. 5	*from passage and applicable to causes of action accruing on or after said date*	52-251c
Sec. 6	*from passage*	New section
Sec. 7	*from passage*	19a-17a
Sec. 8	*from passage*	19a-88(b)
Sec. 9	*from passage*	20-8a
Sec. 10	*from passage*	20-13b
Sec. 11	*from passage*	20-13e(a)
Sec. 12	*from passage*	20-13i
Sec. 13	*from passage*	New section
Sec. 14	*from passage*	New section
Sec. 15	*from passage*	New section
Sec. 16	*from passage*	38a-25
Sec. 17	*July 1, 2005*	New section
Sec. 18	*January 1, 2006*	38a-395
Sec. 19	*from passage*	38a-665
Sec. 20	*from passage*	38a-676
Sec. 21	*July 1, 2005, and applicable to taxable years commencing on or after January 1, 2005*	New section
Sec. 22	*from passage*	Repealer section

Statement of Purpose:

To revise provisions concerning medical malpractice actions, health care provider oversight and discipline, patient safety, medical malpractice insurance rates and reports by insurers.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]